Headquarters U.S. Air Force

Integrity - Service - Excellence

AF Global Surgical Package

in the Ambulatory Data Module (ADM)

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13 Nov 03 AFMSA/SGOZ

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Objectives

- Be aware of what is included in the Surgical Package
- Know how to tell minor and major surgeries
- Know how to code the appropriate surgery
- Coding preoperative care
  - -57 decision for major surgery within 24 hours of surgery
  - -25 E/M as well as minor surgery/procedure on the same day
- Be aware of the proper collection of care in various MEPRS
- Coding entire pre-, intraoperative, but post-operative care not furnished

CMS National Physician Fee Schedule Relative Value File

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Description	Status Code	Not used for Medicare Payment	Work RVU	Fully Implem Non-Fac PE RVU	Non-Fac NA Indicator	Fully Imple-ment Fac PE RVU	Fac NA Indicat	Mal-practice RVU	Fully Imp Non-fac TOTAL	Fully Imple Fac Total	PCTC IND	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC	BILAT SURG	ASST SURG	CO-SURG	TEAM SURG	ENDO BASE
Reconstruction, knee	A		9.36	9.64	NA	9.64		1.29	20.29	20.29	0	090	0.10	0.69	0.21	2	1	2	1	0	
Treat lower leg bone lesion	A		7.97	14.85	NA	14.85		1.08	23.90	23.90	0	090	0.10	0.69	0.21	2	1	1	0	0	
Wrist arthroscopy	A		5.54	5.49	NA	5.49		0.69	11.72	11.72	0	090	0.10	0.69	0.21	2	1	0	0	0	
Wrist arthroscopy/surgery	A		6.01	5.74	NA	5.74		0.82	12.57	12.57	0	090	0.10	0.69	0.21	3	1	2	1	0	29840
Laser tx, skin < 250 sq cm	A		1.15	2.88		0.45		0.09	4.12	1.69	0	000	0.00	0.00	0.00	2	0	1	0	0	
Dermatological procedure	C		0.00	0.00		0.00		0.00	0.00	0.00	0	XXX	0.00	0.00	0.00	0	0	0	0	0	
Pt evaluation	A		1.20	0.74		0.46		0.05	1.99	1.71	7	XXX	0.00	0.00	0.00	0	0	0	0	0	
Athletic train reeval	I		0.00	0.00		0.00		0.00	0.00	0.00	9	XXX	0.00	0.00	0.00	9	9	9	9	9	
Hot or cold packs therapy	B	+	0.06	0.05		0.05	NA	0.01	0.12	0.12	9	XXX	0.00	0.00	0.00	9	9	9	9	9	
Mechanical traction therapy	A		0.25	0.14		0.14	NA	0.01	0.40	0.40	7	XXX	0.00	0.00	0.00	0	0	0	0	0	
Hyperbaric oxygen therapy	A		2.34	0.75	NA	0.75		0.12	3.21	3.21	0	XXX	0.00	0.00	0.00	0	0	0	0	0	
Observation care discharge	A		1.28	0.44	NA	0.44		0.05	1.77	1.77	0	XXX	0.00	0.00	0.00	0	0	0	0	0	
Initial hospital care	A		1.28	0.46	NA	0.46		0.05	1.79	1.79	0	XXX	0.00	0.00	0.00	0	0	0	0	0	
Initial inpatient consult	A		0.66	0.25	NA	0.25		0.04	0.95	0.95	0	XXX	0.00	0.00	0.00	0	0	0	0	0	
Emergency dept visit	A		0.33	0.09	NA	0.09		0.02	0.44	0.44	0	XXX	0.00	0.00	0.00	0	0	0	0	0	
Spontaneous nystagmus test	A		0.40	1.11		1.11	NA	0.04	1.55	1.55	1	XXX	0.00	0.00	0.00	0	0	0	0	0	
Spontaneous nystagmus test	A		0.00	0.91		0.91	NA	0.02	0.93	0.93	1	XXX	0.00	0.00	0.00	0	0	0	0	0	
Spontaneous nystagmus test	A		0.40	0.20		0.20		0.02	0.62	0.62	1	XXX	0.00	0.00	0.00	0	0	0	0	0	

Look at “Global Days” – that will tell minor and major. For major, see how pre-, intra- and post-operative have percentages – that is why you need to know if the post op care is for a procedure done elsewhere.

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Surgical Package

- 000=Endoscopic or **minor procedure** with related preoperative and postoperative relative values **on the day of the procedure only** included in the fee schedule payment amount; **evaluation and management services on the day of the procedure generally not payable.**

- 010=**Minor procedure** with preoperative relative values **on the day of the procedure and postoperative relative values during a 10 day postoperative period** included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.

- 090=**Major surgery** with a **1-day preoperative period and 90-day postoperative** period included in the fee schedule amount.

Surgical Package – strange ones

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- **MMM=Maternity codes; usual global period does not apply, but obstetric package applies.**
- 59400 Obstetrical care
- 59409 Obstetrical care
- 59410 Obstetrical care
- 59412 Antepartum manipulation
- 59414 Deliver placenta
- 59425 Antepartum care only
- 59426 Antepartum care only
- 59430 Care after delivery
- 59510 Cesarean delivery
- 59514 Cesarean delivery only
- 59515 Cesarean delivery

Surgical Package – strange ones

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- **XXX=The global concept does not apply to the code.**
- **Most of the HCPCS, such as injectables, supplies**
- **E/Ms (except for the add on such as critical care)**
- 59050 Fetal monitor w/report
- 59051 Fetal monitor/interpret only

- **YYY=The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing.**
- Many of the “unlisted” codes
- 48999 Pancreas surgery procedure
- 59898 Laparo proc, ob care/deliver
- 59899 Maternity care procedure
-

Surgical Package – strange ones

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- **ZZZ=The code is related to another service and is <u>always</u> included in the global period of the other service.**
- 56606 Biopsy of vulva/perineum, each separate addl lesion (**add on** code to 56605)
- 59525 Remove uterus after cesarean (**add on** code to 59510, 59514, 59515 and 59618)
- 60512 Autotransplant parathyroid (**add on** to a bunch of parathyroidectomies)
- 61316 Incision and subQ placement of cranial bone graft (**add on** to craiectomies)
- 61517 Implt brain chemotherapy agent add-on (**add on** to 61510, 61518)
- Guess you've broken the code – usually add on to other procedure
- E/M add on such as critical care

Quiz

- What do you think the anesthesia codes are?
- 92015 – refraction
- Ambulance runs

Answer

- **Anesthesia – the 0XXXX codes are not on the RVU table. The American Society of Anesthesiologists have a table – more on that next week**
- **Refraction – trick question, XXX. Brought this up because you will notice that there is a "+" in the "Not used for Medicare Payment" because Medicare does not pay for refractions; same with contact lenses and fitting spectacles… (another neat column in the table)**
- **Ambulance – XXX, like just about everything**

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If you don't remember anything else

- Provides time frames that apply to each surgical procedure.
- **XXX=NOT a surgical package**.
- **000**=Endoscopic or minor procedure with related **preoperative and postoperative relative values on the day of the procedure only** included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable.
- **010**=Minor **procedure with preoperative** relative values on the **day of the procedure and postoperative relative values during a 10 day** postoperative **period** included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.
- **090**=Major surgery with a **1-day preoperative period and 90-day postoperative period** included in the fee schedule amount.

Minor Procedures

- **From CPT Expert –**
  - They include the actual surgical procedure, local infiltration, metacarpal and digital block or topical anesthesia (when used) and the normal, uncomplicated postoperative care. When the patient is seen for a routine follow-up postoperative visit within the normal follow-up period, use 99024 for normal uncomplicated postoperative care for documentation purposes only.
- It means, the approach is included. If you do an injection for a local anesthetic, it is included. You need to collect the anesthetic.
- Package includes preop, surgery and post op for 0 (e.g., remove wart), or 10 (e.g., vasectomy) days AND common supplies for that procedure (e.g., initial cast)
  - Post op includes uncomplicated E&M (e.g., clinic visits) – for clinic visits E&M 99499; procedure 99024

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Minor Procedures - Example

- Seen on Friday for stable, chronic hypertension. Patient just turned 50. Scheduled for colonoscopy next Thursday. Code E/M for Friday's visit based on documentation.
- The next Thursday. Patient comes in. Informed consent and pre-op (has anything changed since last Friday) done.
  - Patient has oral medication to make the procedure less stressful. This is not conscious sedation even though you are monitoring the patient because it does not meet the definition of intravenous, intramuscular, inhalation, oral, rectal and or intranasal.
  - Procedure done. Patient has no complications. Patient leaves.
  - Code only the colonoscopy, 45378.
  - Code the E/M with 99499 as a place holder.
  - It was an oral medication (Versed and Demerol), and the patient took it himself (did not need to have it administered) you don't code the administration. The cost of the drug is included in the Practice Expense, so it is not coded.
  - There are "000" global days associated with the procedure. This is a completed surgical package.

Minor Procedures

- OR, the next Thursday. Same colonoscopy, but the patient has a mole on his bum that looks abnormal to the provider. Provider discusses the abnormal mole. The doctor injects 4 cc lidocaine. The doctor removes the lesion using an elliptical excision with the excised diameter 1.1-2.0 cm (the lesion was about the size of a pencil eraser). He closes the laceration with a running subQ suture (only the little ends sticking out). Covers it with a small dressing. Patient leaves.
  - Code the E/M for the discussion of the abnormal mole, with modifier –25 (separate E/M).
  - Code only the colonoscopy, diagnostic, 45378. For the colonoscopy, the surgical package is over.
  - Code the lesion removal 11402 (excised diameter 2.1-3.0 cm) with modifier –51 (multiple procedures). Code the 4 cc lidocaine with J2000. The injection is included in the package as is the dressing. This surgical package is not over as it is a 010 global day package.
- The patient returns the next Thursday, the laceration is healed nicely. No complications. Suture removed. Code with E/M 99499 and procedure 99024.

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Major Surgery – 090 global days

- If you do an evaluation and management within 24 hours of a surgery, make sure you have the –57 decision for surgery modifier (otherwise, the E&M is included in the surgery RVU)
- Try to have surgery within 30 days of decision (if you do the History and Physical then) or you have to do E&M (history and physical) all over again – waste of your and the patient's time. Because the surgery is not within 24 hours of the procedure, you do not need to code the –57.
- Package includes 1 day preop, the surgery and 90 days uncomplicated post op AND common supplies for that procedure (e.g., initial cast)
  - Post op includes uncomplicated E&M (e.g., rounds and clinic visits) – for clinic visits E&M 99499; procedure 99024
- Does not include anesthesia, anesthetic, replacement casts and strapping

MEPRS

- Outpatient preop and postop services will be in the “B” MEPRS
  - For active duty providers, 4th character “A”
  - For resource sharing providers, 4th character “R”
  - For example, AD Ortho=BEAA; RS Ortho=BEAR
- Inpatient professional services (preop, intraoperative and postoperative) surgery will be in the “A” MEPRS
  - For active duty providers, 4th character “A”
  - For resource sharing providers, 4th character “R”
  - For example, AD Ortho=AEAA; RS Ortho=AEAR
- Ambulatory Procedure Visits (APV) are outpatient so they are in the “B” MEPRS with a 4th digit of “5” for active duty, “7” for resource sharing
- Office procedures are outpatient so they are in the “B” MEPRS, just like outpatient preop and outpatient post op

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Example - Ortho

- Patient is rollerblading down a sidewalk with his left arm horizontally extended pointing to a hot car, does not notice the "No Parking" sign until he slams his arm against it. He falls/collapses from the pain. Patient says some obscene words, takes off rollerblades, walks to subway and goes to ER.

ER should code…

- Patient's closed ulnar fx treated at the ER. The ER should have coded:

- E/M of probably 99283-57 due to evaluation of the arm with other minor injuries sustained. The modifier "57" is used because a "decision for surgery" (in this case, "surgery" is a term meaning a CPT code between 10000 and 69999, the surgery section of the book) was made for a "major" surgery (one with a global surgical package of 90 days). For minor "surgeries" (those with 0-10 days), the modifier would have been "25" for a separately identifiable E/M with the minor "surgery," such as strapping an ankle.

Explanation

- NOTE: We did not code modifier "56" preop only, because most of the preop was in the initial evaluation of the arm (including the wet-read of the x-ray) to determine that it was broken, so the credit for that work is in the E/M.
- NOTE: We did not code modifier "52" reduced services because it was not that the physician partially reduced or eliminated the preop, only that it was mostly done in the E/M
- NOTE: You may code uncomplicated fractures w/o manipulation with just the E/M and no procedure code, but this would involve more to remember and the RVUs appear to favor using a procedure code (e.g., fx of 5th R toe with treatment of buddy wrap)

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Dx and Procedure coding

- Dx:arm fx, shoulder pain, E917.8 Striking against other stationary object with subsequent fall, and E849.8 Other specified places. The E-codes would have generated a request for more HIPAA 837 information.

- Procedure1: 25530-54-LT. 54 is "surgery" only [not preop and postop] and earns intraoperative RVU of 69% of the total. The LT is for the left arm. The order was important as the intraoperative is worth the most, the location does not impact the cost so it goes after the 54.
- Procedure2: Q4009 Cast supplies, short arm, adult (11+ years), plaster. This is because some insurance companies include the casting supplies in with the treatment of fracture and some don't. We need to collect it just in case.

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Two Weeks Later

- The patient comes to your orthopedics clinic, no complications. Recast.
- E/M: 99499 (if there was a complication, the E/M would be based on documentation)
- Dx: V54.12 aftercare for healing traumatic fx of lower arm. If the ER was your ER, no E-code as it was already coded for the initial care at your facility. If the ER was downtown, you need to code the E-codes.
- Procedure1: 25530-55-LT. The 25530-55-LT will explain that postop care for the fracture was done and that it should be worth 21% of the treatment of the closed ulnar fracture.
- Procedure2: 29075-LT Application, cast; elbow to finger (short arm). The initial fracture treatment code only includes the initial cast.
- Procedure3: Q4010 Cast supplies, short arm, adult, fiberglass (this one will be on for a while, unlike the first one).

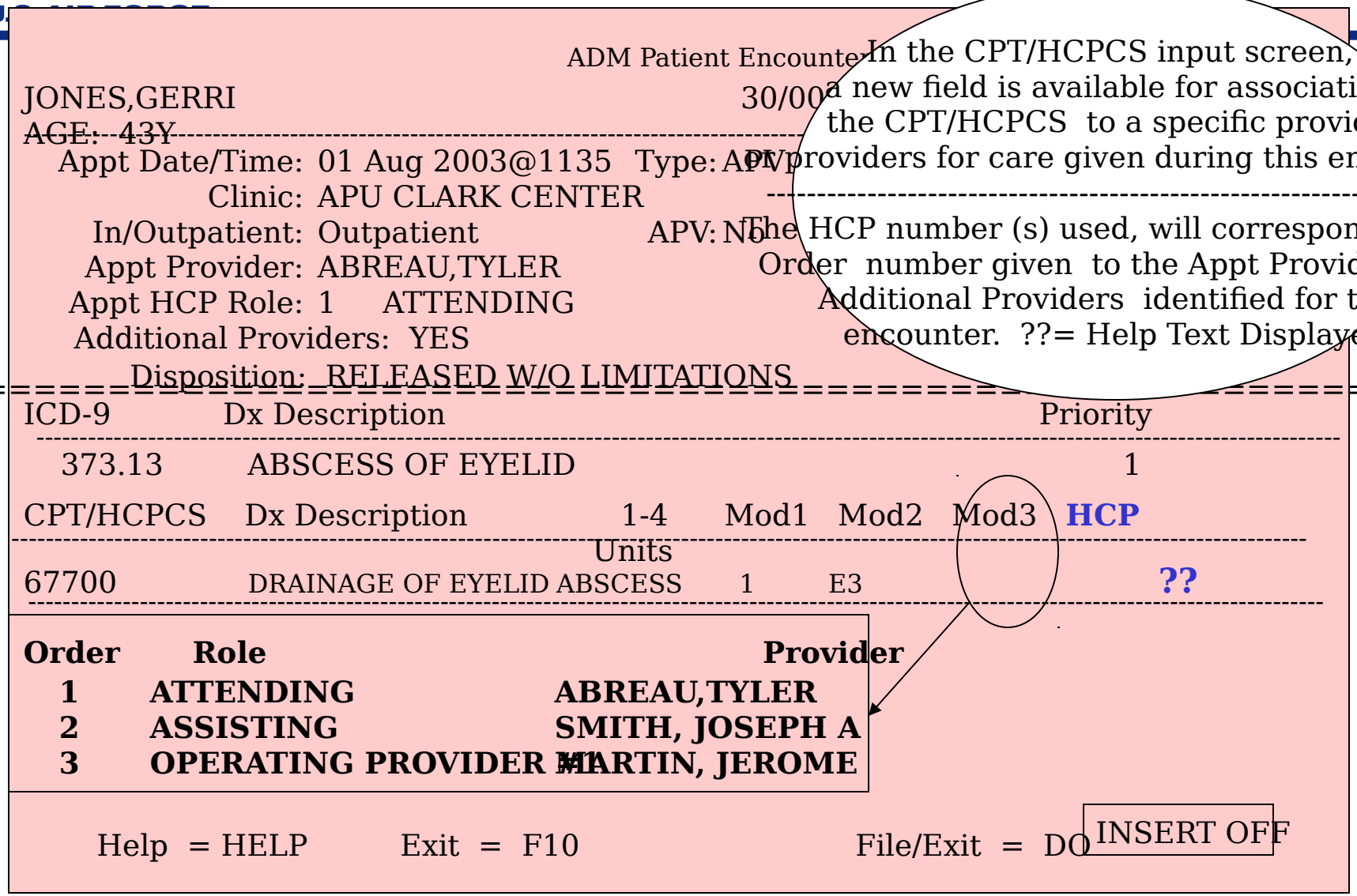
Next visit

- When the patient comes back the rest of the time, up to 90 days after the initial fracture care, the same dx and E/M, but the procedure would be 99024. It does not generate a bill or charge, but shows postop care is done. Code any additional casts and casting supplies if applicable.
- If there had been external fixation (20690-20694), the uncomplicated removal of the external fixation is considered part of the global service.
  - Unless required longer than normal postop period (90 days), then the removal is coded (20694)

Common Surgical Modifiers *(some can't be used until a table is expanded)*

- AM – Physician, team member srvice
- AS – PA, NP or clinical nurse specialist services for assistant at surgery
- E1 upper L eyelid; E2 lower L; E3 upper R; E4 lower R
- F1 L hand 2nd digit; F2 L3rd; F3 L4th; F4 L5th; F5 R thumb
- F6 R hand 2nd digit; F7 R3rd; F8 R4th; F8 R5th; F9 L thumb
- LC – L circumflex coronary artery
- LD – L anterior descending coronary artery
- RC – R coronary artery
- LT – left
- RT – right
- T1 L foot 2nd digit; T2 L3rd; T3 L4th; T5 R great toe
- T6 R foot 2nd digit; T7 R3rd; T8 R4th; T9 L great toe

Coming Soon!! New ADM Screen- Linking CPT/HCPCS to Specific Provider


ADM Patient Encounte
JONES,GERRI
30/00
AGE: 43Y
Appt Date/Time: 01 Aug 2003@1135 Type: APV
Clinic: APU CLARK CENTER
In/Outpatient: Outpatient
APV: No
Appt Provider: ABREAU,TYLER
Appt HCP Role: 1 ATTENDING
Additional Providers: YES
Disposition: RELEASED W/O LIMITATIONS
ICD-9 Dx Description Priority
373.13 ABSCESS OF EYELID 1
CPT/HCPCS Dx Description 1-4 Units Mod1 Mod2 Mod3 HCP
67700 DRAINAGE OF EYELID ABSCESS 1 E3 ??
Order Role Provider
1 ATTENDING ABREAU,TYLER
2 ASSISTING SMITH, JOSEPH A
3 OPERATING PROVIDER #1 MARTIN, JEROME
Help = HELP Exit = F10 File/Exit = DO
INSERT OFF
In the CPT/HCPCS input screen, a new field is available for associating the CPT/HCPCS to a specific provider
providers for care given during this encoun
The HCP number (s) used, will correspond to Order number given to the Appt Provider an
Additional Providers identified for this encounter. ??= Help Text Displayed

Surgical Package

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HCPCS	DESCRIPTION	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC	BILAT SURG	ASST SURG	CO-SURG	TEAM SURG
29870	Knee arthroscopy, dx	090	0.10	0.69	0.21	2	1	1	1	0
29871	KA;infection,for drainage	090	0.10	0.69	0.21	3	1	1	0	0
29873	KA;w/later release	090	0.10	0.69	0.21	2	1	1	1	0
29874	KA;remove FB	090	0.10	0.69	0.21	3	1	0	0	0
29875	KA;synovectomy,limited (plica_	090	0.10	0.69	0.21	3	1	0	0	0
29876	KA;synovectomy,major,2up	090	0.10	0.69	0.21	3	1	1	0	0
29877	KA;debried/shav artic cartilage	090	0.10	0.69	0.21	3	1	0	0	0
29879	KA;abrasion arthroplas/microfx	090	0.10	0.69	0.21	3	1	0	0	0
29880	KA;w/meniscetomy(med&lat)	090	0.10	0.69	0.21	3	1	0	1	0
29881	KA;w/meniscectomy(medORlat)	090	0.10	0.69	0.21	3	1	0	0	0
29882	KA;w/meniscus rep(medORlat)	090	0.10	0.69	0.21	3	1	1	0	0
29883	KA;w/meniscus rep(med&lat)	090	0.10	0.69	0.21	3	1	0	0	0
29884	KA;w/lysis adhes wORw/mani	090	0.10	0.69	0.21	3	1	2	1	0
29885	KA;drill osteochrond w/graft	090	0.10	0.69	0.21	3	1	2	1	0
29886	KA;drill intact osteo	090	0.10	0.69	0.21	3	1	1	0	0
29887	KA;drill int osteo w/int fix	090	0.10	0.69	0.21	3	1	2	1	0
29888	KA,AC ligament repair/aug/recon	090	0.10	0.69	0.21	2	1	2	1	0
29888	KA;post cruciate lig rep/aug/rc	090	0.10	0.69	0.21	2	1	2	1	0
29891	Ankle arthro;exc talus defect	090	0.10	0.69	0.21	2	1	2	0	0
29892	Ankle arthroscopy/surgery	090	0.10	0.69	0.21	2	1	2	0	0

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Multiple Procedures

- 2=Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage

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Multiple Procedures

(just in case you are really interested)

- 3=Special rules for multiple endoscopic procedures apply if procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of this file. Apply the multiple endoscopy rules to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, do not pay separately for the base procedure. Payment for the base procedure is included in the payment for the other endoscopy.
-

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Bilateral Surgery

- 1=150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code. If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

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Assistant at Surgery

(just in case you are really interested)

- 0=Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.
-
- 1=Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.
-
- 2=Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.

- If you have the CPT Expert book, you will see little squares with “80” in them. If the square is black, it means you can get 16% for assistant-at surgery without documentation. If the square is white, you need documentation.

Co-surgeon

(just in case you are really interested)

- 0=Co-surgeons not permitted for this procedure.
-
- 1=Co-surgeons could be paid, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.
-
- 2=Co-surgeons permitted and no documentation required if the two-specialty requirement is met.
-
- 9=Concept does not apply.

Team Surgery

(just in case you are really interested)

- 0=Team surgeons not permitted for this procedure.1=Team surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report.
-
- 2=Team surgeons permitted; pay by report.
-
- 9=Concept does not apply.

RVUs – Work, Practice Expense, Malpractice

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HCPCS	DESCRIPTION	WORK RVU	NON-FAC PE RVU	FACILITY PE RVU	MP RVU	NON-FAC TOTAL	FACILITY TOTAL
29870	Knee arthroscopy, dx	5.07	5.00	5.00	0.67	10.74	10.74
29871	KA;infection,for drainage	6.55	5.98	5.98	0.88	13.41	13.41
29873	KA;w/later release	6.00	6.56	6.56	0.73	13.29	13.29
29874	KA;remove FB	7.05	6.27	6.27	0.87	14.19	14.19
29875	KA;synovectomy,limited (plica_	6.31	5.98	5.98	0.88	13.17	13.17
29876	KA;synovectomy,major,2up	7.92	7.12	7.12	1.11	16.15	16.15
29877	KA;debried/shav artic cartilage	7.35	6.81	6.81	1.03	15.19	15.19
29879	KA;abrasion arthroplas/microfx	8.04	7.21	7.21	1.13	16.38	16.38
29880	KA;w/meniscetomy(med&lat)	8.50	7.46	7.46	1.19	17.15	17.15
29881	KA;w/meniscectomy(medORlat)	7.76	7.04	7.04	1.09	15.89	15.89
29882	KA;w/meniscus rep(medORlat)	8.65	7.34	7.34	1.09	17.08	17.08
29883	KA;w/meniscus rep(med&lat)	11.05	9.16	9.16	1.33	21.54	21.54
29884	KA;w/lysis adhes wORw/mani	7.33	6.76	6.76	1.03	15.12	15.12
29885	KA;drill osteochrond w/graft	9.09	7.98	7.98	1.27	18.34	18.34
29886	KA;drill intact osteo	7.54	6.94	6.94	1.06	15.54	15.54
29887	KA;drill int osteo w/int fix	9.04	7.95	7.95	1.27	18.26	18.26
29888	KA,AC ligament repair/aug/recon	13.90	10.42	10.42	1.95	26.27	26.27
29889	KA;post cruciate lig rep/aug/rc	16.00	12.48	12.48	2.11	30.59	30.59
29891	Ankle arthro;exc talus defect	8.40	7.50	7.50	1.17	17.07	17.07
29892	Ankle arthroscopy/surgery	9.00	7.77	7.77	1.26	18.03	18.03

RVUs

- Work – physician/privileged provider time
- Non-facility Practice Expense – nurses, techs
- Facility Practice Expense – building, equipment, nurses, techs
- Malpractice – malpractice
- Non-facility Total – Work + Non-Fac PE + Malpractice
- Facility Total – Work + Fac PE + Malpractice

- Fac Tot = “25 RVU/day”
- Non-Fac Tot = used for billing

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- Know how to code the appropriate surgery
- Coding preoperative care
  - -57 decision for major surgery within 24 hours of surgery
  - -25 E/M as well as minor surgery/procedure on the same day
- Be aware of the proper collection of care in various MEPRS
- Coding entire pre- and intraoperative, but post-operative care not furnished

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Questions?

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Ambulatory Surgi-Center Groups

- 8 groups – indicated by numbers 1-8
- Levels of institutional services at a Surgi-center
- Examples:
  - 1 – 67415 – Fine needle aspiration of orbital contents
  - 1 – 27323/4 – Biopsy, soft tissue of thigh or knee area; superficial/deep
  - 2 – 27327 – Excision, tumor, thigh or knee area; subQ
  - 3 – 27328 – Excision, tumor, thigh or knee area; deep, subfascial, or intramuscular
  - 4 – 27330 – Arthrotomy, knee; with synovial biopsy only
  - 4 – 27437 – Arthroplasty, patella; w/o prosthesis
  - 5 – 27438 – Arthroplasty, patella; w/prosthesis

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Ambulatory Surgi-Center Groups

- Levels of institutional services at a Surgi-center
- Examples:
- 6 – 66985 – Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
- 6 – 66986 – Exchange of intraocular lens
- 7 – 30450 – Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
- 8 – 66984 – Extracapsular cataract removal with insertion of intraocular lens prosthesis (one state procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification